PRINTED: 09/07/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN4705	A. BUILDING 01 - BUILDING A B. WING	09/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HEALTHCARE-NORTH	5321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the survey conducted on September 6, 2011, no licensure deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 002	**K-130 cntd** doors were found to have properly functioning latches at that time. 3. All doors equipped with lower latching mechanisms on fire doors will be checked on a monthly basis by Facilities Maintenance Director. 4. The Facilities Maintenance Director will inspect all latching fire doors on a monthly basis to ensure the deficient practice will not re-occur. The Facility Maintenance Director and/or the Administrator will report the updates from the monthly inspections until 100% compliance is met to the Quality Assurance Performance Improvement Committee meeting consisting of Administrator, Director of Nursing, Medical Director, Therapy Manager, Activity Director, Dietary Manager, MDS Coordinator, Assistant Directors of Nursing, Team Leaders, Admissions Director, Social Services, Facilities Maintenance Director, Business Office Manager, Housekeeping Director and Laundry Director.	

Division of Health Care Facilities

Annette Williamson — administrator — 9-23-11 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE